General Instructions for Plans

- ***This is a Part D model EOB. Your EOB must include all model language exactly as written, except:***
  - *Minor grammar or punctuation changes and font type or color changes.*
  - *References to a specific plan name in brackets may be replaced with generic language such as "our plan."*
  - *References to Member Services may be changed to the name your plan uses.*
  - *References to the plan's Supplemental Drug Coverage may be changed to the name your plan uses. (This is coverage for non-Part D drugs.)*
  - *References to "cost-sharing tiers" may be expanded to include additional description, including the standardized names of the tiers used by your plan.*
  - *References to "brand-name/tier-level" deductible may be changed to the appropriate name your plan uses.*
  - *Date formatting (such as "mm/dd/yy"), unless specific date formatting instructions are given.*
  - *References to "calendar year" may be changed to "plan year".*
- *Italicized blue text in square brackets is information for the plans, and shouldn't be included in the EOB.*
- *Non-italicized blue text in square brackets may be inserted or used as replacement text in the EOB. Use it as applicable.*
- *The plan type designation (i.e., HMO, PPO, etc.) must be included the first time the plan name is mentioned (see model language for the cover).*
- *Medicare-Medicaid Plans: If you choose the Part D Model EOB, we require the EOB to contain all information and follow all of our model instructions. We expect Medicaid-covered drugs will be included in the model.*

Formatting guidelines

- *So standard window envelopes can be used, the model language in the Appendix, Exhibit A, includes a version of the cover page in portrait orientation and a version in landscape orientation. Plans may use either orientation for all pages of the document. Instructions to plans are shown in this document on the portrait version of the cover. These same instructions apply if the landscape version is used.*
- *The document can be printed double-sided to save space.*
- *Plans are permitted to eliminate empty spaces between sections and/or widen text boxes and columns to save space.*
- *The document must include page numbers.*
- *Plans must include the following information as a footer on every page excluding the cover page (where the information is already included): the plan name, plan phone number, including the TTY number and a statement that calls to the plan are free, and plan URL. Plans may choose to add a header or footer that includes some or all of this information: member identifiers; month and year; additional contact information; page number.*
- *Charts that continue from one page to the next must be marked with "continue" at the bottom on the page that continues. In an actual EOB, rows of a chart must not break across the page (in the model language in this document, rows sometimes break across a page because of the instructions and substitution text).*
- *Costs included may be displayed with or without decimals and cents (e.g. $0.00).*
- *For examples that show versions of the cover page and each section of the EOB, see Exhibits A through F. Exhibit G shows an example of a complete EOB. This exhibit helps you visualize what the document will look like when substitution text is used in various situations.*

Drug Pricing Information (Drug Price & Price Change):

- *The Drug Price column shows the negotiated price as defined at 423.100.*

- *The Price Change shows the percentage change of the drug price from when the prescription was first filled during the current benefit year.*

- *Plans have the flexibility to determine how many lower-cost therapeutic alternative drugs they list; however, plans must provide at least 1 drug for each filled prescription if there is a lower-cost therapeutically equivalent drug available. Plans should use their clinical expertise when deciding which alternative drugs to list. If no lower-cost therapeutically equivalent drug is available, plans may enter "No lower-cost alternative drug is available."*

- *Prior year fills that don't apply to the current EOB or current year gross covered prescription drug costs or true out-of-pocket (TrOOP) amounts don't need to be included in this EOB, and don't require a separate EOB.*

Important things to know

- *"Extra Help" refers to the low-income subsidy (LIS) described in Subpart P of the Part D regulations.*

- *"Out-of-Pocket Costs" and "TrOOP" refer to the enrollee's incurred costs, as defined at 1860D-2(b)(4)(C).*

- *"Total Drug Costs" refers to gross covered prescription drug costs, as defined at 1860D-15(b)(3).*

- *Do not provide information in the Part D EOB about drugs or supplies that would be covered for a beneficiary in original Medicare under Parts A and/or B; for an enrollee in a Part C plan under the plan's Part A/B coverage.*

- *In charts 1, 1A, and 2, the amounts to be used for "you paid" are the final amounts after "other payments" (those made by programs, organizations, or other plans; "other payments" may include TrOOP and non-TrOOP amounts).*

- *Plans may use the optional notes that give members more information about a prescription (such as notes for when a payment for a drug doesn't count toward Out-of-Pocket Costs, or the drug is only partially covered because it's a compound drug that includes non-Part D drugs).*

- *If the Total Drug Costs and Out-of-Pocket Costs change due to an automatic TrOOP balance transfer for the current year, the plan must send the EOB showing the changes in the year-to-date totals in Chart 2 and Chart 3. If a plan transfer happens in a given month, the EOB must be sent even if there were no prescriptions filled in the month before. The note regarding the transferred amounts must stay in Chart 2 for the rest of the year.*

- *When a beneficiary disenrolls from a plan during the plan year, the sponsor must send an EOB to the beneficiary after disenrollment if any claims are processed before the beneficiary disenrolls. For example, if beneficiaries disenroll at the end of August and the plan processes claims in months before they disenroll, the disenrolling plan must send the beneficiaries a final EOB.*

[Insert plan name and/or logo.]
[Insert plan name followed by model type shown in parentheses, e.g., "(HMO)"] is operated by *[insert plan sponsor name]*
[insert return mailing address].

THIS IS NOT A BILL

[Insert beneficiary name.]
[Insert beneficiary mailing address.]

Notice for *[Insert beneficiary name]*	
Your Medicare Number	***[Insert Medicare number]***
Date of This Notice	***[Insert mailing date]***
Claims for	***[Insert name of month and full year]***

Your Medicare Part D Explanation of Benefits (EOB)

This is your "Explanation of Benefits" (EOB) for your Medicare prescription drug coverage (Part D). Your EOB shows the prescriptions you filled, what we paid, what you and others have paid, and what counts towards your Out-of-Pocket Costs and your Total Drug Costs.

- **Your EOB is not a bill.**
  If you paid a co-pay or coinsurance for your drug, the EOB should show the amount you paid. If you participate in the Medicare Prescription Payment Plan, we'll send you a separate monthly billing statement, and amounts shown in this EOB might differ from what you paid. Contact us if you have questions or want more information. Visit Medicare.gov for information about the Medicare Prescription Payment Plan.

- **You may not get an EOB every month.**
  When we get a claim (bill) from your pharmacy, you'll get an EOB the next month. For example, if we get a claim in March, you'll get an EOB in April.

- **Take a minute to look over your EOB.**
  Check your EOB to make sure everything is correct. If you have questions, find mistakes, or suspect fraud, we're happy to help. Call us at the number below.

[Insert plan name and/or logo]
Member Services
If you have questions or need help, call us toll-free *[insert days of week and calling hours].*
[insert phone number]
[add local number if desired]
TTY users call *[insert TTY number]*

Or visit our website:
[insert URL]

For languages other than English:
[Appropriate language as described in the Medicare Communications and Marketing Guidelines, including disclaimers, should be in this document.]

Need large print or another format?
To get this material in other formats, including large type, braille, and translation into other languages, call *[insert plan name]* at the number on this page.

[In chart 1, the amounts to be used for "you paid" are the final amounts after "other payments" (those made by programs, organizations, or other plans; "other payments" may include TrOOP and non-TrOOP amounts).]

CHART 1

Your MONTHLY prescriptions for covered Part D drugs: *[MONTH YEAR]*

[If member has filled prescriptions for non-Part D drugs covered by the plan's supplemental drug coverage during the past month, include Chart 1A in the EOB and add the following sentence here: (Prescriptions for drugs covered by our plan's Supplemental Drug Coverage are shown separately in Chart 1A.)]

Totals for the month of *[Month Year]*
- Your **Out-of-Pocket Costs** amount is **$*[insert total paid by member for the month plus total of "other payments" that count toward the member's TrOOP limit; use "$0.00" if applicable]***
- Your **Total Drug Costs** amount is $*[insert Total Drug Costs for the month; use "$0.00" if applicable]*

Drug Name, Fill Date, Pharmacy, Rx#	You Paid	Plan Paid	Other Payments	Drug Price	Price Change	Lower Cost Alternative Drugs
[insert name of first drug], 40 mg tabs 04/09/25, ABC Pharmacy Rx# 106663421555, 30 day supply	$X	$X	**$X** *[insert "paid by" name of payer]*	$X	*[percent change]*	[insert name of lower cost alternative drug]
[insert name of second drug], 10 mg tabs 04/09/25, ABC Pharmacy Rx# 349000711222, 30 day supply	$X	$X	**$X** *[insert "paid by" name of payer]*	$X	*[percent change]*	[insert name of lower cost alternative drug]
Totals for the month of *[Month Year]*	**$X**	**$X**	**$X**	**$X**		

- *[If the EOB is being sent to a member who hasn't filled any prescriptions for covered Part D drugs during the month, plans must (1) insert the following note in first column: "No prescriptions for covered Part D drugs this month," (2) insert amounts of "$0.00" for the columns labeled "Plan paid," "You paid" and "Other payments...." and (3) omit the row with "Totals for the month..." at the end of this chart.]*
- *You Paid Column: [insert total paid by member for the month. Use "$0.00" if applicable]*
- *Plan Paid Column: [Insert total amount paid by the plan this month; use $0.00 if applicable.]*
- *Other Payments Column: [Insert total amount of "other payments" for the month; use $0.00 if applicable.] [If amount is not $0.00, and there are any payments that **don't** count toward TrOOP, add this text: (Of this amount, $[insert amount that **does** count toward TrOOP] counts toward your Out-of-Pocket Costs.]*

If you have questions, please call *[insert plan name]* at *[insert Member Services phone number]* (TTY *[insert TTY number]*). The call is free. **For more information**, visit *[insert URL]*.

You Paid

This is the amount you paid for each drug. It includes any payments for your drugs made by family or friends. If you participate in the Medicare Prescription Payment Plan, we'll send you a separate monthly billing statement, and the amounts here might differ from what you paid.

Plan Paid

This is the amount *[insert plan name]* paid for each drug.

Other Payments

This shows any payments not included in the "You Paid" and "Plan Paid" columns, such as those made by Extra Help from Medicare, employer or union health plans, TRICARE, Indian Health Service, AIDS drug assistance programs, Manufacturer Discount Program, charities, and State Pharmaceutical Assistance Programs (SPAPs). Some of these payments may not count towards your Out-of-Pocket Costs.

Drug Price

This shows the cost of each drug (including payments made by you, your plan, and others).

Price Change

This shows how the drug price changed (as a percentage) from when your prescription was first filled during the benefit year. You'll only see a drug price change when the quantity dispensed was the same.

Lower Cost Alternative Drugs

This shows drugs that may be an alternative to the ones you're taking now, but with lower cost sharing or a lower drug price. You may want to ask your doctor if the lower cost alternative is right for you.

If you have questions, please call *[insert plan name]* at *[insert Member Services phone number]* (TTY *[insert TTY number]*). The call is free. **For more information**, visit *[insert URL]*.

[In chart 1A, the amounts to be used for "you paid" are the final amounts after "other payments" (those made by programs, organizations, or other plans).]

CHART 1A

Your prescriptions for drugs covered by your plan's Supplemental Drug Coverage: *[MONTH YEAR]*

[Include Chart 1A only if the EOB is for a plan member who has filled at least one prescription during the month for a non-Part D drug that is covered by the plan's Supplemental Drug Coverage.

Don't give information in the Part D EOB about drugs or supplies that would be covered for a beneficiary in original Medicare under Parts A and/or B; for an enrollee in a Part C plan under the plan's Part A/B coverage; or otherwise covered under non-Medicare insurance.]

Your Supplemental Drug Coverage pays for some drugs not generally covered by Medicare. Any prescriptions you filled for these drugs this month are listed in the chart below. **The amounts paid for these drugs do *not* count toward your Out-of-Pocket Costs or Total Drug Costs.**

Drug Name, Fill Date, Pharmacy, Rx#	You Paid	Plan Paid	Other Payments
[Insert name of drug (other than compound) followed by quantity, strength, and form, e.g., "25 mg tabs". Identify compound drugs as such and provide quantity.]	*[Insert amount. Use $0.00 if applicable.]*	*[Insert amount. Use $0.00 if applicable.]*	*[Insert amount. Use $0.00 if applicable. For each payment, identify the payer if known. If payer isn't known, identify as "other payer."]*
[Insert date filled]. [Plans should include the pharmacy name if known. Plans may add the pharmacy location, and other pharmacy information if desired, such as "non-network pharmacy."]			
[Insert prescription number], [Insert amount dispensed, as quantity filled and/or days supply, e.g., "15 tablets", "30 day supply."] [Plans may add more information about the prescription if desired]			
[Plans are encouraged to use the optional notes to give members more information about a prescription, such as notes about general price increases for that drug, or when a payment for a drug doesn't count toward Out-of-Pocket Costs, or the drug is only partially covered because it's a compound drug that includes non-Part D			

If you have questions, please call *[insert plan name]* at *[insert Member Services phone number]* (TTY *[insert TTY number]*). The call is free. **For more information**, visit *[insert URL]*.

drugs. In this section, the plan may also suggest lower-cost alternatives members and their doctors might consider.]			
Totals for the month of *[Month Year]* *[Insert totals for the month under each column. Use $0.00 if applicable]*	$	$	$

[In chart 2, the amounts to be used for "you paid" are the final amounts after "other payments" (those made by programs, organizations, or other plans; "other payments" may include TrOOP and non-TrOOP amounts).]

CHART 2
Your YEARLY spending totals for covered Part D drugs

> Your year-to-date **Out-of-Pocket Costs** amount is
> **$*[insert year-to-date TrOOP; use "$0.00" if applicable]*** (includes what **You Paid** plus **Other Payments**)

	You Paid	Plan Paid	Other Payments	Total Drug Costs
Monthly totals: *[Month Year]*	$X	$X	$X *[insert "paid by" name of payer]*	$X
Year-to-date totals: Jan – [Month Year]	**$X**	**$X**	**$X**	**$X**

- *You Paid Column: [Insert how much the member has paid year-to-date; use $0.00 if applicable.] (Year-to-date total). [If total isn't $0.00 and any of this total doesn't count toward Out-of-Pocket Costs, insert: (Of this amount, $[insert amount paid that does count toward Out-of-Pocket Costs] counts toward your Out-of-Pocket Costs.)]*
- *Plan Paid Column: [Insert how much the plan's paid year-to-date; use $0.00 if applicable.] (Year-to-date total)*
- *Other Payments Column: [Insert year-to-date total for "other payments"; use $0.00 if applicable] (Year-to-date total). [If total isn't $0.00 and there are any payments that don't count toward Out-of-Pocket Costs, insert: (Of this amount, $[insert amount that does count toward Out-of-Pocket Costs] counts toward your "Out-of- Pocket Costs." See definitions in Section 3.)]*
- *[If the member was enrolled in a different plan for Part D coverage earlier in the year, plans must insert the following: "NOTE: Your year-to-date totals shown here include Out-of-Pocket Costs payments of $[insert the TrOOP balance transferred from prior plan] and $[insert amount for Total Drug Costs] in Total Drug Costs made for your Part D covered drugs when you were in a different plan earlier this year."]*
- *[Optional: If corrections have been made that affect amounts shown in monthly summaries earlier in the calendar year, plans may explain in this space: "NOTE: The following [insert whichever applies: correction has OR corrections have OR adjustment has OR adjustments have] been made to amounts that were in a monthly summary sent to you earlier this calendar year: [Plans should give a brief explanation of the correction or adjustment with the change that was made and gives relevant dates and a reason for the change, e.g., clerical error, updated information about the prescription, decision on an appeal, etc." Plans have the flexibility to report such adjustments or corrections to members in other ways instead of, or in addition to, adding this explanatory note to the EOB.]*
- *[Optional: Plans can add as a bullet under "Out-of-Pocket Costs include": "Supplemental drug benefits paid by your plan."]*

You Paid

This is the amount you paid for each drug. It includes any payments for your drugs made by family or friends. If you participate in the Medicare Prescription Payment Plan, we'll send you a separate monthly billing statement, and amounts here might differ from what you paid.

Plan Paid

This is the amount *[insert plan name]* paid for each drug.

Total Drug Costs

This is the total of all payments made for your covered Part D drugs. It includes:

- What the plan pays
- What you pay
- What other programs or organizations pay for your drugs

Other Payments

This shows any payments not included in the "You Paid" and "Plan Paid" columns, such as those made by Extra Help from Medicare, employer or union health plans, TRICARE, Indian Health Service, AIDS drug assistance programs, Manufacturer Discount Program, charities, and State Pharmaceutical Assistance Programs (SPAPs). Some of these payments may not count towards your Out-of-Pocket Costs.

Out-of-Pocket Costs include:

- What you paid when you fill/refill a covered Part D prescription
- Any payments for your drugs made by family or friends
- Any payments made for your drugs by Extra Help from Medicare, employer or union health plans, TRICARE, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs)

Out-of-Pocket Costs DON'T include payments made for:

- Plan premiums
- Drugs not covered by our plan
- Non-Part D drugs (like drugs you get during a hospital stay)
- Drugs covered by certain other programs, such as the Veteran's Administration or Worker's Compensation
- Manufacturer Discount Program
- Selected drug subsidy
- *[insert if applicable:* Drugs covered by our plan's Supplemental Drug Coverage listed in Chart 1A*]*
- *[insert if applicable:* Drugs you got from a non-network pharmacy that doesn't meet our requirements*]*

Learn more

Medicare made the rules about which types of payments count toward "Out-of-Pocket Costs" and "Total Drug Costs." For more details, see *[insert plan name]*'s *Evidence of Coverage* benefits booklet.

[NOTE TO PLANS ABOUT CHART 3:

To standardize the EOB, this section on drug payment stages always shows all 3 stages. When a drug payment stage doesn't apply to members, the model language includes an explanation to say so.

Language in Chart 3 is customized for the payment stage the member is in. Each stage's wording varies, including variations for plan design (e.g., deductible vs. brand-name/tier level only deductible vs. non-deductible) and for LIS (non-LIS vs. LIS). This section can be suppressed when the enrollee is a full benefit dual eligible and is either institutionalized or receiving home and community-based waiver services (LICS level 3).

To make the substitution text easier to follow, this model document gives you different versions of Chart 3 for each payment stage, with separate versions for LIS and non-LIS. The non-LIS versions are shown first, followed by those for LIS.

For a quick overview of how the language and formatting accents change from one stage to the next, for non-LIS and LIS, see the examples in Exhibit C in the Appendix.]

[Use this version of CHART 3 for members <u>without</u> LIS who are in the deductible stage]

CHART 3

Your current drug payment stage

How much you pay for a covered Part D prescription depends on which payment stage you're in when you fill it. This chart helps you understand what stage you were in at the end of ***[insert month and year]*** and when you'll move to the next stage.

Year-to-date totals: Jan – *[insert name of month and full year]*	You're in Stage 1: Yearly Deductible	Stage 2: Initial Coverage	Stage 3: Catastrophic Coverage
Out-of-Pocket Costs	**$X**	*starts when* **Out-of-Pocket Costs** *reach $[insert annual deductible amount]*	*starts when* **Out-of-Pocket Costs** *reach $[insert TrOOP limit]*

You're in Stage 1: Yearly Deductible

- During this payment stage, you (or others on your behalf) pay the full cost of your drugs.
- The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, preventative tetanus and travel vaccines.
- You generally stay in this stage **until you (or others on your behalf) have paid** *$[insert annual deductible amount]* for your drugs. *[If the plan has a brand-name/tier level deductible, insert the following three bullets.]*
- During this payment stage, you (or others on your behalf) pay the full cost of your *[brand-name/tier level]* drugs.
- You generally pay the full cost of your *[brand-name/tier level]* drugs until you (or others on your behalf) have paid $*[insert deductible amount]* for your *[brand-name/tier level]* drugs. $*[insert deductible amount]* is the amount of your *[brand-name/tier level]* deductible.
- As of *[insert end date for the month]* you've paid ***$[insert year-to-date Deductible Drug Costs]*** for your drugs in the deductible.

What happens next?

Once you (or others on your behalf) have paid an additional **$*[insert additional amount needed to satisfy the deductible]* for your drugs,** you move to the next payment stage (Stage 2: Initial Coverage).

About Coverage Stages

- **Stage 1: Yearly Deductible**
  You start in this payment stage each calendar year. In this stage, you pay the full cost of your drugs. **You generally stay in this stage until you've paid the amount of your deductible ($*[insert annual deductible]*).**

If you have questions, please call *[insert plan name]* at *[insert Member Services phone number]* (TTY *[insert TTY number]*). The call is free. **For more information**, visit *[insert URL]*.

- **Stage 2: Initial Coverage**
  In this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. **You generally stay in this stage until your year-to-date Out-of-Pocket Costs reach $*[insert TrOOP limit]*.**

- **Stage 3: Catastrophic Coverage**
  In this stage, the plan pays all of the cost for your covered Part D drugs. You pay nothing. **You generally stay in this stage for the rest of the calendar year.**

[Use this version of CHART 3 for members without LIS who are in the initial coverage stage]

CHART 3
Your current drug payment stage

How much you pay for a covered Part D prescription depends on which payment stage you're in when you fill it. This chart helps you understand what stage you were in at the end of ***[insert month and year]*** and when you'll move to the next stage.

Year-to-date totals: Jan – *[insert name of month and full year]*	Stage 1: Yearly Deductible	You're in Stage 2: Initial Coverage	Stage 3: Catastrophic Coverage
Out-of-Pocket Costs	*lasts until* **Out-of-Pocket Costs** *reach $[insert annual deductible]*	**$X**	*starts when* **Out-of-Pocket Costs** *reach $[insert TrOOP limit]*

You're in Stage 2: Initial Coverage

- During this payment stage, the plan pays its share of the cost of your *[insert if applicable: generic/ tier levels]* drugs and you (or others on your behalf) pay your share of the cost.
- You generally stay in this stage **until your year-to-date Out-of-Pocket Costs reach $*[insert TrOOP limit]*.**
- As of *[insert end date of month]*, your year-to-date Out-of-Pocket Costs were **$*[insert year-to-date out-of-pocket costs]*.**

What happens next?

Once you have **an additional $*[insert amount needed in additional TrOOP to meet the TrOOP limit]*** in Out-of-Pocket Costs, you move to the next payment stage (Stage 3: Catastrophic Coverage).

About Coverage Stages

- **Stage 1: Yearly Deductible**
  You start in this payment stage each calendar year. In this stage, you pay the full cost of your drugs. **You generally stay in this stage until you've paid the amount of your deductible ($*[insert annual deductible]*).**

- **Stage 2: Initial Coverage**
  In this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. **You generally stay in this stage until your year-to-date Out-of-Pocket Costs reach $*[insert TrOOP limit]*.**

- **Stage 3: Catastrophic Coverage**
  In this stage, the plan pays all of the cost for your covered Part D drugs. You pay nothing. **You generally stay in this stage for the rest of the calendar year.**

If you have questions, please call *[insert plan name]* at *[insert Member Services phone number]* (TTY *[insert TTY number]*). The call is free. **For more information**, visit *[insert URL]*.

[Use this version of CHART 3 for members <u>without</u> LIS who are in catastrophic coverage]

CHART 3
Your current drug payment stage

How much you pay for a covered Part D prescription depends on which payment stage you're in when you fill it. This chart helps you understand what stage you were in at the end of *[insert month and year]* and when you'll move to the next stage.

Year-to-date totals: Jan – *[insert name of month and full year]*	Stage 1: Yearly Deductible	Stage 2: Initial Coverage	You're in Stage 3: Catastrophic Coverage
Out-of-Pocket Costs	*lasts until* **Out-of-Pocket Costs** *reach* $*[insert annual deductible]*	*lasts until* **Out-of-Pocket Costs** *reach* $*[insert TrOOP limit]*	**$X**

You're in Stage 3: Catastrophic Coverage

- During this payment stage, the plan pays all of the cost for your covered Part D drugs.
- You pay nothing.

What happens next?

You generally stay in this stage for the rest of the calendar year.

About Coverage Stages

- **Stage 1: Yearly Deductible**
  You start in this payment stage each calendar year. In this stage, you pay the full cost of your drugs. **You generally stay in this stage until you've paid the amount of your deductible ($*[insert annual deductible]*).**

- **Stage 2: Initial Coverage**
  In this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. **You generally stay in this stage until your year-to-date Out-of-Pocket Costs reach $*[insert TrOOP limit]*.**

- **Stage 3: Catastrophic Coverage**
  In this stage, the plan pays all of the cost for your covered Part D drugs. You pay nothing. **You generally stay in this stage for the rest of the calendar year.**

[Use this version of CHART 3 for members <u>with</u> LIS who are in the initial coverage stage]

CHART 3
Your current drug payment stage

How much you pay for a covered Part D prescription depends on which payment stage you're in when you fill it. This chart helps you understand what stage you were in at the end of ***[insert month and year]*** and when you'll move to the next stage.

Year-to-date totals: Jan – *[insert name of month and full year]*	Stage 1: Yearly Deductible	You're in Stage 2: Initial Coverage	Stage 3: Catastrophic Coverage
Out-of-Pocket Costs	*not applicable*	**$X**	*starts when* **Out-of-Pocket Costs** *reach* $*[insert TrOOP limit]*

You're in Stage 2: Initial Coverage

- You start in this payment stage when you fill your first prescription of the year.
- During this payment stage, the plan pays its share of the cost of your *[insert if applicable: generic/ tier levels]* drugs and you (or others on your behalf, including "Extra Help" from Medicare) pay your share of the cost.
- You generally stay in this stage **until your year-to-date Out-of-Pocket Costs reach $***[insert year-to-date TrOOP].** As of *[insert end date of month]*, your year-to-date Out-of-Pocket Costs were $***[insert year-to-date TrOOP].**

What happens next?

Once you have **an additional $***[insert amount needed in additional TrOOP to meet the TrOOP limit]* **in Out-of-Pocket Costs,** you move to the next payment stage (Stage 3: Catastrophic Coverage).

About Coverage Stages

- **Stage 1: Yearly Deductible**
  Because you get "Extra Help" from Medicare, Stage 1: Yearly Deductible doesn't apply to you.

- **Stage 2: Initial Coverage**
  In this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. **You generally stay in this stage until your year-to-date Out-of-Pocket Costs reach $***[insert TrOOP limit]*.

- **Stage 3: Catastrophic Coverage**
  In this stage, the plan pays all of the cost for your covered Part D drugs. You pay nothing. **You generally stay in this stage for the rest of the calendar year.**

If you have questions, please call *[insert plan name]* at *[insert Member Services phone number]* (TTY *[insert TTY number]*). The call is free. **For more information**, visit *[insert URL]*.

[Use this version of CHART 3 for members with LIS who are in catastrophic coverage]

CHART 3
Your current drug payment stage

How much you pay for a covered Part D prescription depends on which payment stage you're in when you fill it. This chart helps you understand what stage you were in at the end of **[insert month and year]** and when you'll move to the next stage.

Year-to-date totals: Jan – *[insert name of month and full year]*	Stage 1: Yearly Deductible	Stage 2: Initial Coverage	**You're in Stage 3: Catastrophic Coverage**
Out-of-Pocket Costs	*not applicable*	*lasts until **Out-of-Pocket Costs** reach $[insert TrOOP limit]*	**$X**

You're in Stage 3: Catastrophic Coverage

- During this payment stage, the plan pays all of the cost for your covered Part D drugs.
- You pay nothing.

What happens next?

You generally stay in this stage for the rest of the calendar year.

About Coverage Stages

- **Stage 1: Yearly Deductible**
  Because you get "Extra Help" from Medicare, Stage 1: Yearly Deductible doesn't apply to you.

- **Stage 2: Initial Coverage**
  In this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. **You generally stay in this stage until your year-to-date Out-of-Pocket Costs reach $[insert TrOOP limit].**

- **Stage 3: Catastrophic Coverage**
  In this stage, the plan pays all of the cost for your covered Part D drugs. You pay nothing. **You generally stay in this stage for the rest of the calendar year.**

If you have questions, please call *[insert plan name]* at *[insert Member Services phone number]* (TTY *[insert TTY number]*). The call is free. **For more information**, visit *[insert URL]*.

CHART 4
Changes to our Drug List that affect drugs you take

We may make changes to our Drug List during the year, like adding new drugs, removing drugs, changing coverage restrictions, or moving drugs from one cost-sharing tier to another. **The information below provides updates that affect plan-covered prescriptions you filled in** *[insert coverage year].*

- *[Use this section to give formulary updates that affect drugs the member is taking, i.e., any plan-covered drugs the member filled a prescription for during the current calendar year while a member of the plan. Include updates only if they affect drugs the member is taking. (Changes to the formulary from one year to the next are announced in the ANOC and do not need to be included in the EOB.) This would include covered Part D drugs and supplemental drugs listed in Charts 1 and 1A of Section 1, but not those that would be covered for a beneficiary in original Medicare under Parts A and/or B; for an enrollee in a Part C plan under the plan's Part A/B coverage; or otherwise covered under non-Medicare insurance.]*

- *[If there are no updates, replace all of the text that follows this section with:* "At this time, there are no new or upcoming changes to our Drug List that will affect the coverage or cost of drugs you take. (By "drugs you take," we mean any plan-covered prescriptions you filled in *[insert year]* as a member of our plan.)"*]*

- *If an update is for a negative formulary change that isn't a formulary maintenance change, insert:* "If you're taking this drug now, this change won't affect your coverage for this drug for the rest of the plan year."*]*

- *[Below we show model language for reporting several common types of changes to the Drug List for you to use as applicable. Plans may adapt this language as needed for grammatical consistency, accuracy, and relevant detail (e.g., describing a drug as "brand-name" or "generic"). Plans may also explain changes and suggest specific drugs that might be suitable alternatives. For changes we haven't given you model language for, use the model language below as a guide. Also, see the examples in Exhibit E in the Appendix.]*

[Insert name of step therapy drug; plans may also insert information about the drug's strength or the form it's dispensed in (e.g., tablets, injectable, etc.)]

Step therapy

- Starting *[insert effective date of change]*, "step therapy" will be required for this drug. This means you will be required to try *[insert either: a different drug first OR one or more other drugs first]* before we'll cover *[name of step therapy drug]*. This requirement encourages you to try another drug that costs less but is just as safe and effective as *[insert name of step therapy drug]*. If *[insert either: this other drug doesn't OR the other drugs don't]* work for you, the plan will then cover *[insert name of step therapy drug]*.

Understanding these changes

See the next page for places to get help and more information about your options.

- *[If applicable, plans may insert information that shows possible alternate drug(s). For example, "(You and your doctor may want to consider trying [alternate-drug-1] or [alternate drug-2]. Both are on our Drug List and have no coverage restrictions. They're used in similar ways as [name of step therapy drug] and they're on a lower cost-sharing tier.)"]*

How much will you pay?

The amount you'll pay depends on which drug payment stage you're in when you fill the prescription. To find out how much you'll pay, call *[insert plan name]* at *[insert member services phone number]* (TTY *[insert TTY number]*).

If you have questions, please call *[insert plan name]* at *[insert Member Services phone number]* (TTY *[insert TTY number]*). The call is free. **For more information**, visit *[insert URL]*.

Understanding these changes

See the next page for places to get help and more information about your options.

- *[If applicable, plans may insert information that shows possible alternate drug(s). For example, "(You and your doctor may want to consider trying [alternate-drug-1] or [alternate drug-2]. Both are on our Drug List and have no coverage restrictions. They're used in similar ways as [name of step therapy drug] and they're on a lower cost-sharing tier.)"]*

How much will you pay?

The amount you'll pay depends on which drug payment stage you're in when you fill the prescription. To find out how much you'll pay, call *[insert plan name]* at *[insert member services phone number]* (TTY *[insert TTY number]*).

[Insert name of drug with quantity limits; plans may also insert information about the drug's strength or the form it's dispensed in (e.g., tablets, injectable, etc.)]

Quantity limit

- Starting *[insert effective date of change]*, there'll be a new limit on how much of the drug you can have: *[insert description of how the quantity will be limited].*

Understanding these changes

See the next page for places to get help and more information about your options.

How much will you pay?

The amount you'll pay depends on which drug payment stage you're in when you fill the prescription. To find out how much you'll pay, call *[insert plan name]* at *[insert member services phone number]* (TTY *[insert TTY number]*).

[Insert name of prior authorization drug; plans may also insert information about the drug's strength or the form it's dispensed in (e.g., tablets, injectable, etc.)]

Prior authorization

- Starting *[insert effective date of change]*, "prior authorization" will be required for this drug. This means you or your doctor need to get approval from the plan before we'll cover it.

Understanding these changes

See the next page for places to get help and more information about your options.

- *[Plans may insert more explanation, for example, "Your choices include asking for prior authorization to continue having this drug covered or changing to a different drug.]*

How much will you pay?

The amount you'll pay depends on which drug payment stage you're in when you fill the prescription. To find out how much you'll pay, call *[insert plan name]* at *[insert member services phone number]* (TTY *[insert TTY number]*).

If you have questions, please call *[insert plan name]* at *[insert Member Services phone number]* (TTY *[insert TTY number]*). The call is free. **For more information**, visit *[insert URL].*

[You can use the language below with appropriate modifications and within required timeframes to notify enrollees about immediate generic substitutions by Part D sponsors meeting the requirements, as well as other generic changes.

[Insert name of brand-name drug that has been or will be replaced with generic or whose preferred or tiered cost-sharing or restrictions or both changed (or will change) with the addition of the new generic drug; plans may also insert information about the strength or form in which the drug is dispensed (e.g., tablets, injectable, etc.)]

Generic replacement

- Starting *[insert effective date of the change]*, the brand-name drug *[insert name of brand-name drug to be replaced with generic] [insert either: "will be" OR "was"] [state if brand-name drug is being substituted or if there is a change to the brand-name drug's cost-sharing tier or restrictions with the addition of the generic drug or both. For instance,]* removed from our Drug List. We *[insert either:* "will add" *OR* "added"*]* a new generic version of *[insert name of brand-name drug to be replaced with generic]* to the Drug List (it is called *[insert name of replacement generic drug]*).

- We're *[insert either: "replacing" OR "replaced" [name of brand-name drug] OR [insert as applicable:* "changed" *OR "are changing" "cost-sharing" OR* "restrictions" *OR "cost-sharing and restrictions" for [insert brand-name drug]* because *[insert name of generic drug],* a *[insert if applicable "new"]* generic version of *[insert name of brand-name drug to be replaced with generic],* is available now. *[Indicate tier placement of generic drug. For instance, "[Insert name of generic drug]* (tier *[insert cost-sharing tier number or name for the replacement generic drug])* is on *[insert either:* "the same" *OR* a "lower" cost-sharing tier than *[name of brand-name drug],* the drug it *[insert either:* "is replacing" *OR* "replaced"*] [insert if generic drug is on a lower cost-sharing tier:* (tier *[insert cost-sharing tier number or name for the brand-name drug that is being replaced.])*

Understanding these changes

If your doctor thinks this generic drug isn't right for you, you can ask us to make an exception.
See the next page for places to get help and more information about your options.
[Plans may insert further information if applicable. For example, "This change can save you money because [insert name of replacement generic drug] (tier [insert cost-sharing tier number or name for the replacement generic drug]) is in a lower cost-sharing tier than [insert name of brand-name drug to be replaced with generic] (tier [insert cost-sharing tier number or name for the replacement generic drug])."

How much will you pay?

The amount you'll pay depends on which drug payment stage you're in when you fill the prescription. To find out how much you'll pay, call *[insert plan name]* at *[insert member services phone number]* (TTY *[insert TTY number]*).

If you have questions, please call *[insert plan name]* at *[insert Member Services phone number]* (TTY *[insert TTY number]*). The call is free. **For more information**, visit *[insert URL]*.

[Insert name of drug for which cost-sharing will increase; plans may also insert information about the strength or form in which the drug is dispensed (e.g., tablets, injectable, etc.)]

Cost-sharing increase

- Starting *[insert effective date of the change]*, *[insert description of the change, for example, "the brand-name drug [insert name of drug for which cost-sharing will increase] will move from tier 2 to a higher cost-sharing tier (tier 3)."]*

Understanding these changes

See the next page for places to get help and more information about your options.

[Plans may add more information, for example, "(You and your doctor may want to consider trying a lower cost generic drug, [insert name of lower-cost generic drug], which is in cost-sharing tier [insert number or name of cost-sharing tier].)"

How much will you pay?

The amount you'll pay depends on which drug payment stage you're in when you fill the prescription. To find out how much you'll pay, call *[insert plan name]* at *[insert member services phone number]* (TTY *[insert TTY number]*).

Important things to know about your drug coverage and your rights

See mistakes or have questions?

If you have questions, see mistakes, or suspect fraud, call *[insert plan name]* Member Services at *[insert Member Services phone number]* (TTY *[insert TTY number]*). You can also find answers to many questions online at *[insert URL]*. Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

You can also call your State Health Insurance Assistance Program (SHIP). The name and phone numbers for your state SHIP are in Chapter 2, Section 3 of your *Evidence of Coverage*.

Get help with your options

Here are some things you can do to help you and your doctor manage any changes in coverage:

Call *[insert plan name]* Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor to find a covered drug that might work for you and have fewer restrictions or a lower cost.

You and your doctor can ask us to make an exception for you. This means asking us to agree that the change in coverage or cost-sharing tier of a drug doesn't apply to you. To learn how to ask for an exception, see *[MA-PD insert:* **Chapter 9***] [PDP insert:* **Chapter 7***]* in the *Evidence of Coverage*, "What to do if you have a problem or complaint."

Get help paying for your drug coverage

"Extra Help" from Medicare. If you meet certain income and resource limits, you may qualify for Extra Help. This program helps pay for your Medicare drug coverage costs, such as plan premiums, deductibles, and costs when you fill your prescriptions. To see if you qualify for Extra Help, complete an application online at https://secure.ssa.gov/i1020/start. You can also call Social Security toll-free at 1-800-772-1213 (TTY 1-800-325-0778).

Help from your State Pharmaceutical Assistance Program. Many states have State Pharmaceutical Assistance Programs (SPAPs) that help people pay for prescription drugs based on financial need, age, or medical condition. Each state has different rules. To find out if your state has a State Pharmaceutical Assistance Program, visit Medicare.gov and search for "SPAP." Or, check with your local State Health Insurance Assistance Program (SHIP).

Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan can help you manage your drug costs by spreading them out during the year as monthly payments. This program is available to anyone with Medicare Part D and can be especially helpful to people with high cost sharing earlier in the plan year. Contact us or visit Medicare.gov to learn more about this program.

Get help with drug coverage or payment problems

Your *Evidence of Coverage* explains what to do if you have problems related to your drug coverage and costs. Here are the chapters to look for:

[MA-PD insert: **Chapter 7.***] [PDP insert:* **Chapter 5.***]*: Asking the plan to pay its share of a bill you have received for covered services or drugs
[MA-PD insert: **Chapter 9.***] [PDP insert:* **Chapter 7.***]*: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Get more details in the *Evidence of Coverage [if EOB is for a member with LIS, insert "and LIS Rider"]*

The *Evidence of Coverage* is our plan's benefits booklet. It explains your drug coverage and the rules you need to follow to use your coverage. To get a copy of the *Evidence of Coverage* in your mail or email, call *[insert plan name]* Member Services at *[insert Member Services phone number]* (TTY *[insert TTY number]*). You can also get this document online at *[insert URL]*. [If EOB is for a member with LIS, insert: Your LIS Rider ("Evidence of Coverage Rider for People Who Get Extra Help Paying for their Prescriptions") is a short separate document that tells what you pay for your prescriptions.]*

Your right to appeal

When we decide whether a drug is covered and how much you must pay, it's called a "coverage decision." If you disagree with our coverage decision, you can appeal (see *[MA-PD insert:* Chapter 9*] [PDP insert:* Chapter 7*]* of the *Evidence of Coverage*).

Medicare sets the rules for how coverage decisions and appeals are handled. These are legal procedures and the deadlines are important. The process can be expedited if your doctor tells us that your health requires a quick decision.

If you have questions, please call *[insert plan name]* at *[insert Member Services phone number]* (TTY *[insert TTY number]*). The call is free. **For more information**, visit *[insert URL]*.